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THE PART II EXAMINATION: POLITICAL EXERCISE OR NATIONAL STANDARD?

I recently had the pleasure of spending \$1200 and 6 hours participating in the political exercise known as the Medical Council of Canada's Qualifying Examination Part II (MCCQE Part II). This examination was created as the result of the interpretation by the Medical Council of Canada (MCC) of a parliamentary act that instructs the council to establish a national qualification for physicians. Do the Royal College of Physicians and Surgeons of Canada (RCPSC) and the College of Family Physicians of Canada (CFPC) not already fulfil that requirement, since this grand, new, 2-year prelicensure training program now forces us all to obtain certification by one of these two colleges? Let us not forget that a key reason for the introduction of this examination was portability. Portability, as you may know, is a concept that fails to have any meaning in Canada, since every province mounts larger and larger barricades to prevent any "outsiders" from entering. Portability is now such a sham that it is easier for physicians to move to the United States and set up a practice there than to move within Canada.

The medical system in Canada is entering an interesting phase; many of the rules governing the lives and careers of the new graduates and trainees are in place for political

rather than practical reasons. The organizations that portray themselves as trying to improve the quality of medicine or as helping the country respond to a crisis in physician supply have motives different from those they state. The MCCQE Part II has never been shown, and never will be shown, to improve the quality of physicians in Canada. If it does function as a quality-assurance measure, then why not administer it to all physicians practising in Canada? Should we not ensure that all of the physicians in this country can pass this examination, which tests the core knowledge required by every physician? Of course, Canada-wide testing would never be allowed to proceed because of the loud outcry from the medical establishment. However, established physicians are more than happy to nod knowingly and say that the examination, as it stands now, is necessary to ensure that all of us are good, caring physicians first and specialists second. Yet the true reason for the existence of the MCCQE Part II is little more than the continuing political battle among the RCPSC, the CFPC and the MCC.

Consider the billing restrictions in many urban areas. Do these billing restrictions and disincentives apply to all family physicians in that area? No, they apply only to new graduates. As a result, as we have seen in Nova Scotia, there is an excess of family physicians in the Halifax area. They are all billing 100%,

doing few if any calls and working with complete specialist coverage. In the rural areas, where all family physicians still do calls at night, work shifts in the local emergency department and practise obstetrics, family physicians are leaving for greener pastures, where their work will be better appreciated and compensated. The unthinkable solution would be to cut the pay of all family physicians in the Halifax area by a small proportion, rather than cutting that of new graduates by a prohibitive amount. The reason this is not done is simply that the Medical Society of Nova Scotia (MSNS) has a say in the billing restrictions, and it is trying to protect its members at all costs, not help balance physician resources.

An interesting sidelight is that all of the residents at Dalhousie University are members of the MSNS, but the society chooses to ignore that fact as much as possible. When the president of the MSNS was recently asked what new graduates who want to practise family medicine in Halifax should do, he offered little more than the suggestion that they should move away.

As governments continue to cut the measly pay of all physicians and try to force them to serve as the gatekeepers of the failing medical system, we must search for a solution to these problems for the coming years, not just the next month or two. One solution to the physician-resource problem is to reduce med-

ical-school enrolment. Cut the number of students in all schools by 15%, get rid of one of the Ontario schools completely, and then let us discuss physician resource management. However, no one and no group would bother to fight for a real solution to today's problems concerning training of new graduates and manpower distribution; physicians and organizations are all far too busy working as hard as they can to protect their own proverbial butts.

As a fellow physician recently said, "Medicine is the only profession that eats its young."

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[Drs. Dauphinee and Harley respond:]

Many of Dr. Kennedy's comments concerning the Council and its examinations are inaccurate or speculative.

The examination did not result from an interpretation of an act. Creation of the MCCQE is one of the express obligations of the MCC under the Canada Medical Act¹ and the council's letters patent. The concept of a two-part examination is not new. It was the rule for years; the one-part examination administered from 1970 to 1992 was the exception. The Canada Medical Act was created to stop each provincial licensing authority from setting its own examination — which was the prevailing situation until 1912. At the creation of the MCC the licensing authority of each province had to be, and still is, represented by two members on the council.

The RCPSC and the CFPC do not have and were never intended to have the mandate to license physicians or determine qualification for licensure in Canada. That mandate resides in the provincial medical licensing authorities, since health is a provincial responsibility in Canada.

Furthermore, licensing authorities are not represented on either college. Some provinces require a certificate from one of the colleges as a prerequisite for licensure but only if the applicant has passed the MCCQE Part I and Part II, since the MCCQE is "their examination."

As for portability, barriers to mobility are a current problem stemming from agreements between provincial medical associations and provincial governments. However, as Kennedy does not appear to appreciate, the provincial ministers of health, at a meeting held in Halifax Sept. 14 to 15, 1994, rejected all barriers based on training and other factors and placed a time limit on them. Second, the new interprovincial agreement on trade does not permit such barriers and outlines a mechanism to resolve conflicts. That agreement also mandates the establishment of competency-based national standards, which already exist in the case of medicine in the form of licensure by the MCC. Clearly, to achieve portability, national standards are a prerequisite; fortunately, they already exist.

Kennedy's statements about the quality of physicians are unsubstantiated and incorrect. For those in practice, the issue is the quality of physicians' practices, not the "quality of physicians." Examinations and postgraduate processes have been shown to lessen the risk of performance problems in later professional life. The Objective Structured Clinical Examination was established to assess physicians whose practices have been found to have deficiencies during a peer review. The examination has been given in three western provinces and Ontario for some years. Furthermore, the licensing authorities have proposed systematic monitoring of all physicians with diagnostic-skills testing if problems are identified.

As for Kennedy's comments about political battles among the

MCC, the RCPSC and the CFPC, we refer him to our second point, and we note that formal discussions concerning rationalization of post-graduate evaluation in Canada took place last summer and are continuing with Dr. Douglas Wilson of Edmonton as chair.

We, too, are upset about balkanization and about decisions made on the basis of where a physician is trained and other such factors, and we expressed this in a recent commentary by one of us (W.D.D.) and MCC Past-President Dr. Dennis A. Kendel ("Barriers to interprovincial physician mobility," *Can Med Assoc J* 1994; 151: 1579-1580).

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Reference

1. *Canada Medical Act*, SC 1911, 2 Geo 5, c 16

CMA AND DIVISIONS CONSIDER PAYMENT OPTIONS

I would like to reply to the letter "Payment options lacking" (*Can Med Assoc J* 1995; 152: 15), by Dr. Adam Steacie.

Although the Canadian health care system is clearly experiencing rapid reform, one area of increasing importance to physicians is payment models other than fee-for-service. To this end, CMA and its divisions, which are ultimately responsible for developing and negotiating such models, have dedicated considerable resources to ensure that physicians' professional and economic needs are met.

As a recent example, a regional invitational workshop was cohosted by the New Brunswick Medical As-